# JIG-SO PROJECT JOURNEY

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**Exploring practices and experiences within a Welsh multi-agency young families project.**

**Final Report**

This report was written and prepared by Dr Michael R.M. Ward, Professor Susanne Darra, Catherine Jones and Sara W. Jones from Swansea University and with cooperation from Wendy Sunderland-Evans, Mike Davis and Anna-Marie Sales from Abertawe Bro-Morgannwg University Health Board/Swansea council JIG-SO[1].

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**Acknowledgements**

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# Executive Summary

JIG-SO is an early intervention, multi-agency project, consisting of a dedicated team of Midwives, Family Facilitators, Nursery Nurses, Early Language Development Workers and Managers. The team works across Swansea, to support the well-being of vulnerable and expectant young parents [aged 16-24] from 17 weeks of pregnancy and throughout the child's infant years. It is part of the Welsh Government's *Flying Start* and *Families First* programmes. This report draws on a yearlong qualitative and quantitative research study to explore the practices and experiences of staff and service users.

## Key Findings

- Our research found that a close, collaborative working relationships and joined-up practice between the multi-agency partners, enabled a high level of communication to meet service users' often complex needs. These joined-up working practices within JIG-SO, or what we term the 'JIG-SO model' created a team or 'family' unit around a young parent.

- These collaborative ways of working, link into the Welsh Government's 'Sustainable Development Principle' as laid out in the *Well-being of Future Generations (Wales) Act 2015*.

- This family unit or 'JIG-SO model' approach led to better outcomes for the young parents and a large proportion who were referred to the project by the local authority, were closed to social services involvement or removed from the social service's 'at risk' register. After engaging with the team these young parents were also more likely to remain with their children.

- Statistical analysis revealed that JIG-SO clients showed improvements in measurable health outcomes. High levels of smoking cessation, alcohol abstention, longer breastfeeding duration and dietary improvements were reported. Clients also reported feeling more confident as a parent and rated themselves higher in self-assessed scores on child-care activities and parent-child relationship building behaviours, than they did before their engagement with the service.

- The young parents we interviewed reported that positive relationships formed with

members of staff due to the personal attributes of the practitioners (defined as being supportive, friendly, empathetic, reliable and non-judgmental). This allowed them to feel like they were cared for and could connect on a personal level and that they were not being stigmatized, thereby feeling that they could trust them.

- We found that different programmes of support were available pre and post birth to provide an invaluable level of healthcare information and support for young parents and their children.

- This support was fostered by the multi-agency workers through one-on-one work, but also through the facilitation of family support group classes and forums. Young parents reported that they also benefited from additional hours with practitioners because they took the time to explain procedures relating to labour, birth and parenthood. They also told us that staff took them to food banks, provided advice on employment, education, housing or universal credit issues and as a result, they felt more supported and prepared to be a parent.

- These programmes of support allowed many young parents to share their experiences and learn from others accessing JIG-SO services and to build friendships and parental networks.

- This package of support also went beyond parenting and child healthcare information classes. One particular course was a six-week relationships programme aimed at both expectant and new parents.

- This programme provided advice on what a healthy relationship between parents might look like and through the group's facilitators, provided a safe space to discuss often challenging topics. These included what abusive partner behaviour looked like, strategies for challenging stressful situations, coping with arguments and dealing with disagreements.

- It was in this safe space that young fathers were encouraged to talk about their ideas of what defines masculinity and being a man. Through exercises which challenged gender stereotypes and discussions around what traditional masculine practices looked like, young men were able to questions the consequences of destructive or negative behaviours on themselves, their partners and children. It was here that 'caring masculinities' were fostered.

**Implications**

- At a time when funding and the futures of support services are under threat, this report demonstrates the vital role that agencies such as JIG-SO play in enabling young families to construct better futures for themselves. By learning from this example of good practice, and drawing on the expertise from this collaborative approach, other local authorities could greatly benefit from what we term the 'JIG-SO model'.

- This study adds to the existing body of knowledge of how parenting programmes can provide support for wider social determinants of health including issues surrounding housing, employment and furthering education which can contribute to the health of individuals and should be seen as an example of good practice.

- Additionally, it also adds to a small body of knowledge which explores how the inclusion of fathers in these programmes can benefit the whole family and help prepare them for the journey ahead.

- Finally, this report highlights how JIG-SO is operating within a troubling policy backdrop which includes *The 1001 Critical Days Strategy* and *Adverse Childhood Experiences* [ACEs] agenda. We argue that these are individualized solutions that ignore poverty and social inequality and are only part of what is needed to combat the disadvantaged socio-economic circumstances which shape many young parents' lives.

**Section 1. Background to the Research**

**Introduction**

This report provides an overview of a research study into the practices and experiences within a Welsh multi-agency young families project, its key findings and conclusions. The objectives of the study were to discover ways to potentially improve the project, to publicise findings from the research, to build research capacity within health and social care providers and feed evidence into important UK and wider policy agendas surrounding young families.

**Background**

It is well recognised that families, especially young families, need a wide range of support (Robb et al., 2013). In order to tackle and reduce health and social inequalities this support must start before birth and be followed throughout the life of a child (Nolan et al., 2012). Only then can the close links between early disadvantage and poor future life changes be broken (Marmot et al., 2010). It has been further suggested that teenage pregnancy is strongly related to social and health inequalities, which can further present themselves at birth and throughout the life course (Hutchinson, 2007). For the mother, associated risks include, high blood pressure, complications during pregnancy, depression and social isolation (Smyth and Anderson, 2014). Associated risks for babies included a 20% higher risk of premature birth, 15% risk of a lower birth rate, 45% higher risk of infant death and a 30% higher chance of the baby being still born (Public Health England & Department of Health, 2009; Public Health England and Local Government Association, 2015). There is also a 63% higher risk of living in poverty for children born to young mothers (Public Health England and Local Government Association, 2015). Furthermore, a growing body of research highlights the challenges and risks men face as young fathers. Tarrant and Neale (2018, 4-5) suggest that 'by healthcare services engaging more with men the positive changes this engenders can have positive outcomes for women as well as men, because men are more likely to engage in healthier relationships with their partners. Improvements in fathers' skills, capacities and confidence have a cyclical affect, influencing the health and behaviours of children as well'. It has been further found that amongst all young parents there is a low uptake of antenatal and postnatal services (Arthur, Unwin and Mitchell, 2007) and that they are less likely to access and

maintain contact with these services due to fear of stigmatisation and being judged (Rudoe and Thomson, 2009).

Given these challenges, there are currently national early intervention strategies in place which aim to support young parents and improve long-term health and social outcomes (Department of Health 2010; Welsh Government 2011, 2013). These national strategies feed into wider global debates around child and adolescent health (World Health Organisation [WHO], 2018). However, in recent years alongside these strategies, a somewhat competing parenting deficit model has developed by policy makers in England and Wales (see Macvarish et al., 2015). These include the *1001 Critical Days Manifesto* (Loughton, 2015) and the *Adverse Childhoods Experiences (ACEs) Wales Survey* (Public Health Wales, 2015). Whilst we do not deny the importance of health harming behaviours on children and young people's future life chances, we do find these individualistic approaches to parenting problematic and the lack of discussion around the impact of poverty, and social marginalisation is often unclear and under reported (see Kelly-Irving and Delpierre, 2019; White et al., 2019).

One key factor which has been identified in reducing health and social inequalities are prudent healthcare strategies which suggest that through coproduction, public and professionals can be equal partners. The *Well-being of Future Generations (Wales) Act 2015* (Welsh Government, 2015) argues that this is key to improving the social, economic, environmental and cultural well-being of Wales. To create a more sustainable and equal Wales, public bodies in Wales are required to undertake the "Five Ways of Working" approach. (Welsh Government, 2015: 7).

 These ways of working consist of:

- Prevention

- Integration

- Involvement

- Collaboration

- Long Term

**The JIG-SO Project**

JIG-SO is one example of this co-production healthcare strategy approach being fostered in Wales. Funded through the Welsh Government's *Flying Start Programme*, and *Families First Agenda*, the multi-agency early intervention community project was set up in May 2016. The multi-agency project consisting of a dedicated team comprises of four Family Facilitators, two Early Language Development Workers; four Nursery Nurses; Six Midwives and one Administrator. The Midwives and Nursery Nurses are led by a Lead Midwife and all others are led by a Manager. The team works across Swansea to support the well-being of vulnerable and expectant young parents [aged 16-24] during their pregnancy and throughout the child's infant years.

The team offers a service from 17 weeks of pregnancy, as parents are more receptive to information when they are expecting a child (WHO, 2018). This multi-agency, early intervention and long-term engagement approach was adopted to provide holistic support for young parents and help them to meet their child's health and emotional wellbeing needs in order to thrive as a family. This research project kept in mind how the JIG-SO team met the "5 Ways of Working" as laid out by the *Well-being of Future Generations (Wales) Act 2015* and the impact this has on young families.

**Research Questions**

The study sought to address the following research objectives:

- To explore in what ways the JIG-SO project is 'working', from the perspectives of service users and service providers.
- To discover how the project might be improved.
- To consider how the project might be replicated in other areas of Wales (and the UK)

**Section 2. Methodology**

**Introduction**

This study was conducted using a mixed methods approach, combining both quantitive and qualitative social science data collection and analysis (Denscombe, 2008). In this section of the report we outline the phases of the research process, how we recruited participants and our collaborative approach which engaged service users. We also outline how we analysed the data and addressed ethical considerations.

**Research Phases**

The study was split into three phases. Phase one consisted of a desk-based review of the literature relating to similar multi-agency services and the policy context. This was accompanied by a quantitative descriptive data analysis of routinely collected anonymised outcomes and evaluation data from JIG-SO. This consisted of a systematic analysis of 'hard outcomes' (clearly defined and measurable health and social outcomes) pertinent to the JIG-SO project population, such as breastfeeding rates, smoking cessation and social services involvement. In addition, 'soft outcomes' were also assessed using programme assessment tools and surveys with service users.

The second phase of the project involved participant observations by members of the research team of different JIG-SO programmes of support for young families and focus group interviews with the service users. These programmes included a women's antenatal group, a peer-support mother and baby group, parenting classes and a six-week healthy relationships course for young men and women. This third programme helped explore the experiences of young men, who were fathers or expectant fathers and might not have accessed the other groups.

The third phase concentrated on the JIG-SO project office and members of staff working within the service. Non-participant observational research was conducted by a member of the research team over a three-day period. This was followed by two focus group interviews with staff members who consented to further exploration of their experiences of working within the project.

**Recruitment and collaborative research**

Alongside the research team, service users were also involved in the study. A group of young mothers proposed the different arms of the study and offered to help us to devise questions for interviews and focus groups at a meeting held in early 2018 when we began the research. Some of the women who attended on that day offered to join us in a research development and delivery group. Other women and young men from the service also joined in the research development and delivery group, which met regularly throughout the year. One of the young women had previously attended short courses on interviewing people for social research, she expressed great interest in helping us with the study and was involved in some of the focus groups with young people. Social Media [Facebook] also proved an invaluable site for communicating with service users and although this was not used as a data source, it enabled young people to keep in touch with research developments and to recruit participants to the focus group interviews. Other young people were recruited via staff and through research engagement in different settings for considerable periods of time. For example, one of the research team spent six weeks attending a healthy relationships course. In order to achieve a truly co-produced study, and to ensure that service users felt that their voice was heard, they were also involved in some of the initial data analysis.

**Data analysis**

The quantitative data from phase one of the project was analysed using descriptive statistics [see Part One of the findings section]. Data from phases two and three [see Part Two, Three and Four of the findings section] consisted of focus group interviews and fieldnotes taken from observing different programmes of support within the JIG-SO project. A flexible semi-structured interview schedule was used, in which participants were encouraged to talk about their experiences and current lives. A particular focus with the service users was on their identities as young parents, their experience of support services and their relationships with the multi-agency staff members. For staff members, questions were asked about their experiences of working within JIG-SO and their views on collaborative working and inter-team dynamics.

All interviews were digitally recorded, anonymised, transcribed and then analysed (together with fieldwork notes kept by the researchers) by the research team using thematic analysis to identify key themes (Braun and Clarke, 2012). The team used a primarily inductive approach to thematic

analysis, where codes and themes were developed from the data content. In practice, this meant thoroughly reading and re-reading transcripts, coding the data in relation to the research questions with the aid of a Computer Assisted Qualitative Data Software [CAQDAS] package and developing themes as individuals, and then a review of these themes in discussion with the wider team to finalise them. The focus group data that was collected with service users was also shared and discussed within the research development and delivery group meetings. Here researchers and service-users within the group compared and discussed the analysis together.

**Ethical considerations**

The study followed ethical protocols used by Swansea University, Abertawe Bro-Morgannwg University [ABMU] Health board and ethical approval was gained from the College of Human and Health Sciences Research Ethics Committee of the home institution. Research participants, whether young people or staff, were provided with information sheets explaining the research process and issues such as confidentiality and they were invited to sign consent forms. All names throughout this report have been changed.

**S**ection 3. Findings

This section of the report outlines the key findings from both the quantitative and qualitative phases. Several different themes and outcomes were identified across the data. The first part of this section provides an overview and analysis of the quantitative data held by JIG-SO in 2017/18. Parts Two, Three and Four of this section draw on the qualitative data collection conducted by members of the research team, across JIS-SO's different programmes of support. These provide insights into service user's experiences of the agency, their relationships with project staff, and the perspectives of the practitioners who worked within the service.

**Part One Quantitive data findings**

Evaluation data shows some preliminary successes of the early social intervention by the JIG-SO multi-agency approach, which meets the Welsh Governments "5 Ways of Working" strategy (Welsh Government, 2015). Evaluation data includes Welsh Government Key Performance Indicators (KPIs) for maternity services and outcome measures relating to parenting intervention by the JIG-SO Family Facilitators and Early Language Development workers.

**Measures used**

Data were collected on key 'hard outcomes' (clearly defined and measurable health and social outcomes) pertinent to the JIG-SO project population, such as breastfeeding rates, smoking cessation and social services involvement. In addition, so-called, 'soft outcomes' were also assessed. Soft outcomes often represent an intermediary stage to achieving a hard outcome, such as gains in knowledge, changes in attitudes or improvements in interpersonal skills (Welsh European Funding Office [WEFO], 2003). 'Distance travelled' is an established way of measuring these soft outcomes, useful both for research and in practical terms so that clients and practitioners can track progress (Dewson, Eccles, Tackey and Jackson, 2000; WEFO, 2003). In the JIG-SO project, young parents were asked to self-complete surveys or 'wheels'; a Likert-scale with 10 intervals representing a scale of feeling or agreement with a statement. A baseline score was completed at the start of involvement with JIG-SO and then repeated some months later (on average after four-six months).

**Analysis**

Descriptive statistics provide a summary of the measurement outcomes and where available these have been compared to the local health board and Welsh national averages. IBM Statistical Package for Social Sciences (SPSS) was also used for inferential statistical analysis in order to provide some further insights where appropriate.

**Results**

In 2017/18 combined there were 192 completed Midwifery evaluations, which contained data on health outcomes such as breastfeeding and smoking.  The distance travelled 'wheels' as outlined above, were also completed by all JIG-SO workers. Table 1 below outlines the number of completed wheels for each staff group. Midwives data were separated into two years as different questions were asked in 2017 and 2018 so they could not be combined.

|  | Number of complete wheels |
|---|---|
| Midwives (2017) | 160 |
| Midwives (2018) | 44 |
| Nursery nurses (2017/18) | 109 |
| Early Language Development Workers (2017/18) | 47 |
| Family facilitators (2017/18) | 67 |

**Table 1**

**JIG-SO Involvement**

Engagement with JIG-SO by service users was generally very high, with 87% of service users engaging well with the service and 68.2% completing the core JIG-SO midwifery programme. Many JIG-SO service users were also registered with other services working in low-income communities in Swansea; for example, 42.2% were also registered with *Families First*, and 55.7% were in *Flying Start* areas. However, this indicates that, if not for JIG-SO, a significant proportion of these families may not have been involved with any services additional to the standard health board midwifery and health visiting programmes.  Only 3.1% of JIG-SO clients attended the local

hospital parent-craft sessions, implying that the vast majority received all their information on pregnancy, birth, infant feeding and preparation for parenthood, either from their own midwife or their JIG-SO Midwife.

*Midwifery*

Data were collected on the midwifery visits. Across 2017 and 2018, JIG-SO midwives visited women during the antenatal period a median average of 6 times. The maximum number of antenatal visits received was 31 and the minimum was one. The median number of postnatal visits was 3, though one person saw their JIG-SO midwife 12 times and the person receiving the fewest number of postnatal visits saw their JIG-SO midwife once.

The primary method of involvement with the JIG-SO was via home visits, with 59.9% of clients only seeing their JIG-SO midwife at one-to-one visits. However, 39.6% also attended JIG-SO midwifery groups.

*Parenting*

In 2017, family facilitators were involved with 138 families, and in 2018, 135 families. Across 2017/18, 151 of the families working with JIG-SO were also involved with social services. Of these 151 families, family facilitators undertook a median average of 6 one-to-one visits. One family received as many as 47 visits, however 27 families had no one-to-one visits, due to poor engagement with the service. 41.7 % of the 151 families also attended JIG-SO parenting groups. Of those who attended the groups, the median number of group visits was 6.

**Health in Pregnancy**

*Smoking*

In 2017/18, 52.6% of JIG-SO clients smoked prior to becoming pregnant. Of these, 25.5% stopped smoking during pregnancy. This is a far greater rate of smoking cessation than the local health board average, which shows that around 6% of women registered with ABMU health board in 2017-18 stopped smoking during pregnancy, despite younger and socially disadvantaged women being much more likely to continue smoking throughout pregnancy (ASH Scotland, 2012; Bottorff., et al, 2014). Carbon monoxide monitoring was offered, but these tests were either declined or were not recorded by midwives, so data were insufficient to analyse.

*Alcohol*

Only 2 of JIG-SO 192 female clients in 2017/18 reported continuing to drink alcohol during their pregnancy. However, drinking alcohol in pregnancy is likely to be underreported; the Institute of Alcohol Studies reported in 2017 that the UK has one of the highest rates of foetal alcohol syndrome in the world, with around 40% of British women admitting to drinking during pregnancy (Institute of Alcohol Studies, 2017). Alcohol consumption during pregnancy is also more likely amongst younger mothers than any other group (Bottorff et al, 2014).

*Diet*

70.8% of the JIG-SO clients in 2017/18 reported that they had improved their diet since becoming pregnant, with many reporting eating more fruit and vegetables, and reducing intake of processed 'junk' food and sugar. Many stated that they had started to eat meals more regularly, more home cooked meals and fewer takeaways.

*Breastfeeding*

In 2017, breastfeeding data were available for 101 women involved with JIG-SO. In 2018, complete data were available for 91 women. Table 2 below shows the percentage of women breastfeeding, compared with the ABMU health board data and Wales as a whole.

| | JIG-SO | ABMU | Wales |
|---|---|---|---|
| | 2017 | | |
| At Birth | 69.3% | 64.6% | 56.7% |
| At 10 days | 48.5% | 28.9% | 42.6% |
| At discharge from JIG-SO (around 28 days) or at 6 weeks (ABMU/Wales) | 39.6% | 33.0% | 34.2% |
| | 2018 | | |
| At Birth | 58.2% | 54.2% (Jan – Sept) | 57.8% (Jan – Sept) |
| At 10 days | 26.4% | 34.1% (Jan – Sept) | 44.5% (Jan – Sept) |
| At discharge from JIG-SO (around 28 days) or at 6 weeks (ABMU/Wales) | 22.0% | 33.0 % (Jan – Sept) | 34.16% (Jan – Sept) |

**Table 2 (ABMU and Welsh data derived from StatsWales, 2019)**

A high proportion of women in the JIG-SO population were breastfeeding at birth, and in 2017, this figure was higher than that of the local health board. It was a little lower in 2018, however, 58.2% is likely to be a much higher proportion of women breastfeeding than would be expected to be seen in a population of low-income, younger mothers. A large review of breastfeeding in 151 primary care trusts in England showed that women in the most deprived areas showed a 21-31 % reduced odds of breastfeeding when compared with the least deprived areas (Oakley, Renfrew, Kurinczuk and Quigley, 2013). Furthermore, the same study and several others have shown that older maternal age is strongly associated with breastfeeding with teenage mothers often considered to be the least likely population group to initiate and continue breastfeeding (Oakley et al., 2013 McAndrew et al., 2012).

While the reasons for low breastfeeding rates in low-income younger mothers are multifactorial, studies have shown that teenage mothers have poorer knowledge about breastfeeding when compared with mothers over 20 years old (Dewan et al., 2002). Improving knowledge about breastfeeding for younger mothers was therefore a key outcome for the JIG-SO project.

The wheels indicated an increase in knowledge about benefits of breastfeeding during involvement with JIG-SO. When asked 'How much do you know about the benefits of breastfeeding?' JIG-SO clients showed an increase in self-reported scores from a mean at the start of their involvement with the JIG-SO midwives of 6.79/10 (SD: 2.57), to a final mean score of 9.45/10 (SD: 1.09). A repeated measures ANOVA found this effect to be statistically significant [$F_{(1, 203)}$ 207.9, $p<0.000$]. See Chart 1 below, which shows the mean scores with a 95% confidence interval.

**Chart 1: Self-reported distance travelled.**
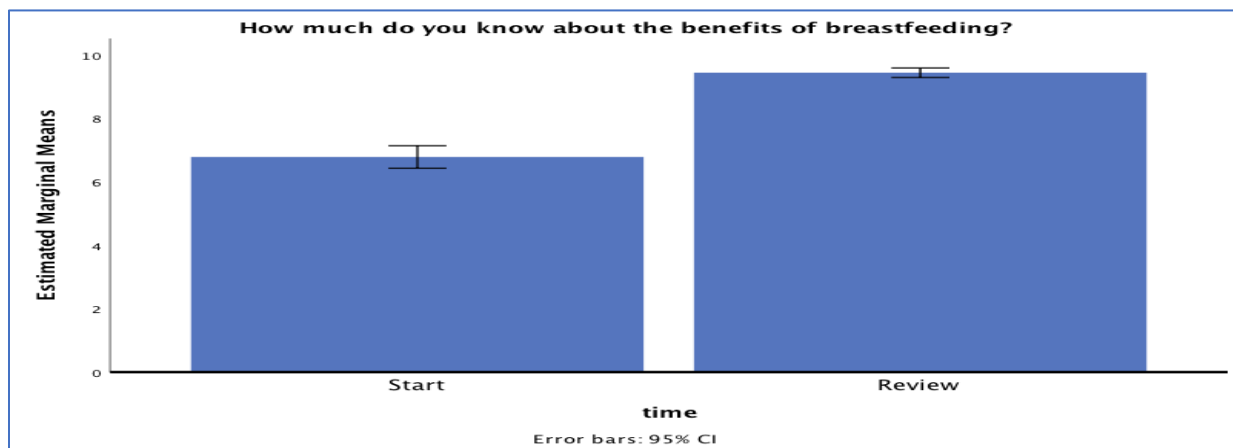
Practical support from a knowledgeable peer or professional is often cited as important for breastfeeding (MacGregor and Hughes, 2010; Shortt, McGorrian, and Kelleher, 2013). While all women who engaged with the project were either offered or received (in some cases extensive) support for breastfeeding, the degree of support did not seem to affect hard outcomes. The number of antenatal visits by a JIG-SO midwife did not statistically correlate with whether the woman breastfed at birth. Nor did the number of post-natal visits by a JIG-SO midwife have any statistical association with breastfeeding at 10 days or at discharge. However, according to women's feedback, 82% reported that their JIG-SO midwife had influenced their decision to breastfeed.

**Transition to parenthood**

Becoming a parent is a time of major personal development and adjustment, especially for young people and those who may have had difficult upbringings themselves. Parents who were exposed to Adverse Childhood Experiences (ACEs) in their own childhood, may be predisposed to stress, anxiety and depressive symptoms in parenthood and problematic intimate relationships (Hughes et al., 2017; Young-Wolff et al., 2018).

Pregnancy and early infancy are also critically important periods in a child's life, which lay the foundation for later learning and development. In particular, the quality of the bond between parent and child has a significant influence on the child's social, emotional, physical and interpersonal wellbeing (Kennel and McGrath, 2007). Developing positive relationships between parents and the new baby, within the parental partnership and the wider family are therefore important both for the young people transitioning to parenthood and for children (Kennell and McGrath, 2007; Deave, Johnson and Ingram, 2008).

A high proportion of parents in the JIG-SO population had experienced ACEs when compared to the Wales average (see Charts 2 and 3 below), therefore improving parenting skills, confidence and family relationships were key outcomes for JIG-SO.

**Charts 2 and 3: Proportion of parents exposed to Adverse Childhood Experiences (ACEs)**
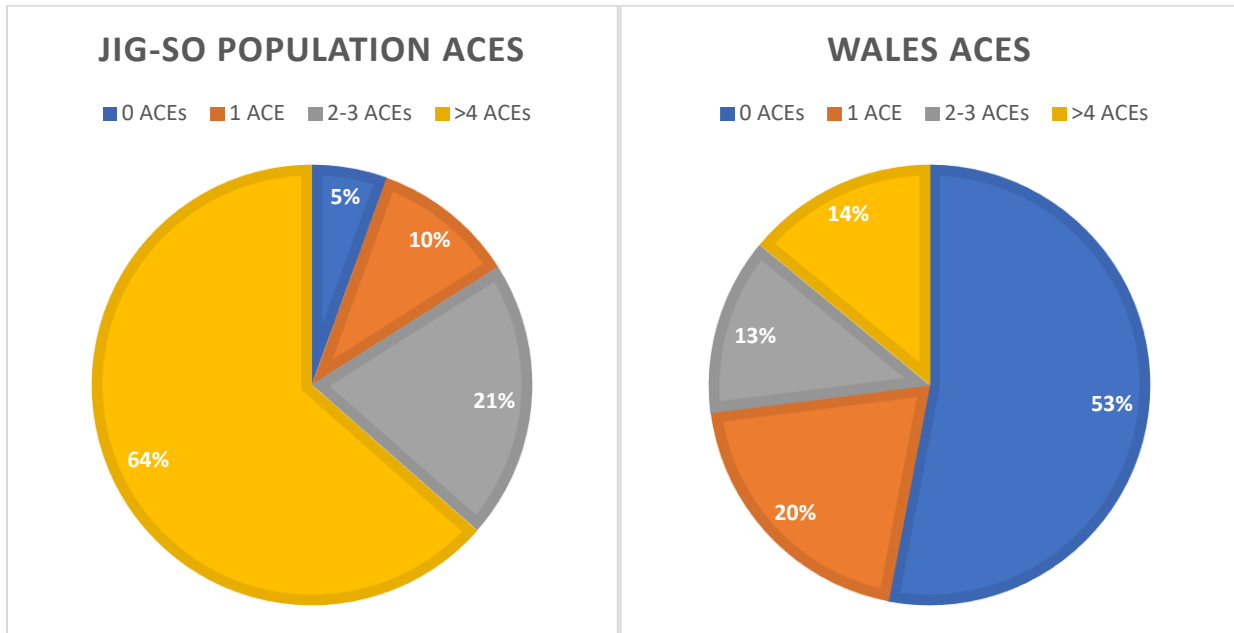


## Confidence as a parent and practical skills

Parents who were asked (N=70) reported increases in self-reported confidence from the start of their involvement with the JIG-SO family facilitators. See Chart 4 below, which shows the mean scores with a 95% confidence interval.

**Chart 4: Self-reported distance travelled.**
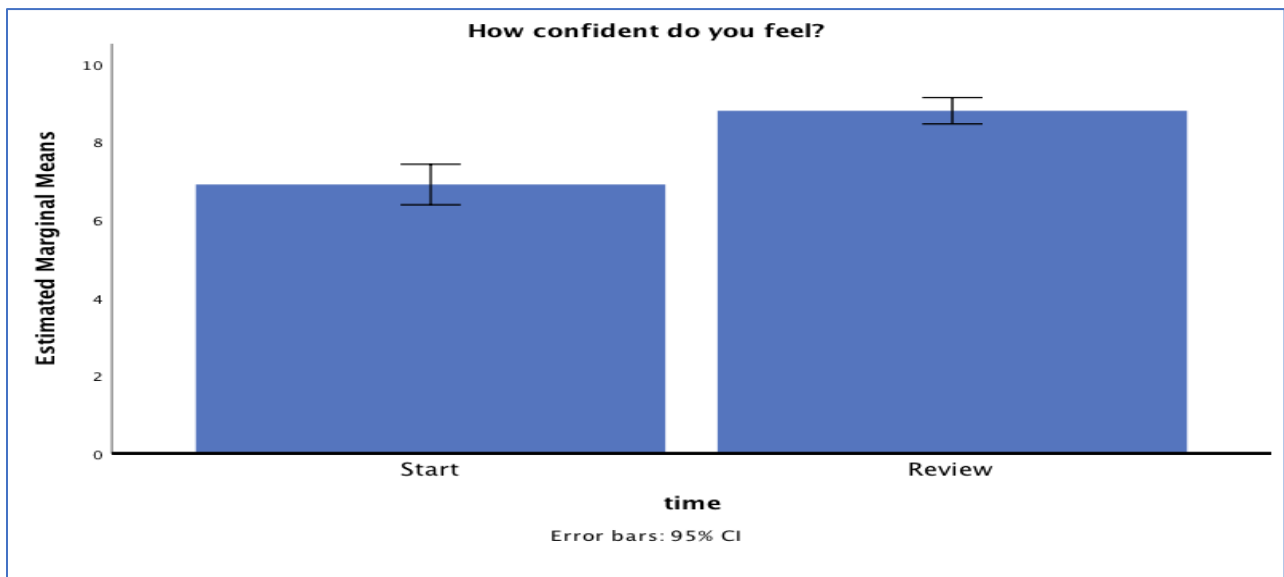
Nursery nurses worked closely with JIG-SO parents to increase knowledge and confidence in practical baby-care. Table 3 below shows the outcomes of the distance travelled wheels.

**Table 3: Practical baby-care skills and infant safety**

| Question/statement | N | Mean score at start (SD) | Mean score at review (SD) | Repeated measures ANOVA for the within subjects difference |
|---|---|---|---|---|
| How confident do you feel about handling and the early days with your new-born? | 107 | 7.01 (2.11) | 9.43 (1.13) | $F(1, 106)$ 188.8, $p<0.000$ |
| How confident are you in feeding your baby and knowing how many feeds needed in a day? | 107 | 6.21 (2.31) | 9.68 (0.58) | $F(1, 106)$ 286.4, $p<0.000$ |
| Do you know about advice on safer sleeping? | 107 | 5.92 (2.35) | 9.76 (0.49) | $F(1, 106)$ 297.6 $p<0.000$ |
| How confident are you about sterilization of equipment for your baby? | 107 | 5.93 (2.70) | 9.63 (0.86) | $F(1, 106)$ 297.6 $p<0.000$ |

Self-reported increases in knowledge on safer sleeping and sterilization were especially large; both questions showed an improvement of around 38 percentage points, indicating the low baseline level of knowledge in these areas, which are critical to infant safety, and the success of JIG-SO engagement. In addition to the wheel questions, women also unanimously reported to midwives that they understood information on reducing the risk of Sudden Infant Death Syndrome (SIDS), safe handling of the new-born and reduction of home accidents.

*The parent child relationship and child development*

JIG-SO workers also encouraged activities, which facilitate bonding with baby, both during the ante-natal period through tapping, talking and singing to the bump, and also in infancy and early childhood. JIG-SO clients demonstrated statistically significant increases in self-reported wheel

scores to the following questions/statements (Table 4) indicating improvements in relationship and bonding with the children and attention to their child's developmental needs:

**Table 4: Relationship with child and attention to developmental needs.**

| Question/statement | N | Mean score at start (SD) | Mean score at Review (SD) | Repeated measures ANOVA for the within subjects difference |
|---|---|---|---|---|
| Do you know how to communicate with your baby in the womb? | 204 | 5.44 (2.57) | 9.50 (0.80) | $F_{(1, 203)}$ 543.5, $p<0.000$ |
| I have a good relationship with my child | 47 | 7.79 (2.23) | 8.62 (2.05) | $F_{(1, 46)}$ 7.57, $p=0.008$ |
| I read and share books/stories with my child | 47 | 6.70 (2.35) | 8.60 (1.69) | $F_{(1, 46)}$ 25.1, $p<0.000$ |
| I spend time playing with my child | 47 | 6.96 (2.39) | 8.38 (2.28) | $F_{(1, 46)}$ 12.5, $p=0.001$ |

**Family Relationships**

Social relationships play a central role in the wellbeing of both parents and children and the stability of the family. Absence of supportive relationships or chaotic family environments may adversely affect health and social outcomes for both parents and children (Coldwell, Pike and Dunn, 2006; Jaffee, et al., 2012). JIG-SO clients reported statistically significant improvements in family relationships [$F_{(1, 66)}$ 23.7, $p<0.000$] and reported feeling more supported [$F_{(1, 66)}$ 31.4, $p<0.000$] during involvement with the service.

*Social Services Involvement*

Across 2017/18 JIG-SO worked with 151 families who were also involved with local authority social services as shown in Table 5 below.

**Table 5: Cases involved with JIG-SO, social services and outcomes, 2017/18.**

| | N | | N | % |
|---|---|---|---|---|
| Engaged with JIG-SO | 132 | Closed with a positive outcome | 78 | 59 |
| | | Ongoing work | 31 | 23.5 |
| | | Children removed from parent's care | 15 | 11.4 |
| | | Children undergoing Public Law Outline (PLO) proceedings / foster placement with ongoing work | 3 | 2.3 |
| | | Closed to JIGSO but still open to Social services | 3 | 2.3 |
| | | Moved out of county | 2 | 1.5 |
| | | | | |
| Did not engage with JIG-SO | 19 | Ongoing work with Social Services | 4 | 21 |
| | | Child removed from parents' care | 15 | 79 |
| Total | 151 | | | |

The majority of families working with JIG-SO closed to the service with a positive outcome. Of the 151 families open to both social services and JIG-SO, 132 families engaged well with JIG-SO, and of these, 15 children (11.4 %) were removed from their parents' care, leaving 87.1 % of those who engaged with the service having either a positive outcome, or work ongoing. In contrast, 19 families did not engage with JIG-SO and 15 (79%) of these families had the child removed from their care, giving a positive outcome (or work ongoing) rate of only 21%.

The number of one-to-one visits by family facilitators was significantly associated with outcomes; A Mann Whitney U test found that families whose child's name was removed from the child protection register had received more one-to-one visits from JIG-SO family facilitators (Mdn=11) than those whose child's name remained on the register (Mdn=5) [U =722.5, p=0.001]. Statistically significant results were also found for group attendances; families who had their

child's name removed from the child protection register had attended JIG-SO groups more often (Mdn=34) than those whose child's name remained on the register (Mdn=14) [U =149, p=0.04].

We now move on to concentrate on the qualitative data we collected through observations and of the different programmes and support groups organised and run by the JIG-SO team. These observations are supported by data extracts from the focus groups we conducted with JIG-SO and importantly, the young people themselves who were the service users of the project.

**Part Two: The Service Users**

**Women's antenatal group, a peer-support mother and baby group and parenting classes**

**Introduction**

This section will report the key qualitative findings from four focus groups (n-18) and one observation of an antenatal and peer support group session. They participants also discussed at length the support they received from JIG-SO midwives. The key findings identify two main themes, having support and gaining information and knowledge. As this report made clear in the above section, providing support is something which is integrated to all aspects of JIG-SO and young parents reported that the personalities of the practitioners played an important role in the support they received.

**Support**

Many of the young parents reported that they received "support left, right and centre" [Olivia, Focus Group (FG) 1] during their time with JIG-SO. This support ranged from antenatal to postnatal sessions, attending group sessions, but also support with aspects including securing housing, applying for grants and accessing furniture and baby items. The formation of relationships with practitioners influenced experiences of support. Positive relationships formed due to the personal attributes of the practitioners including being friendly, open, empathetic, and non-judgemental which allowed them to feel like they could connect on a personal level. Young parents reported that they benefited from additional hours with practitioners because they took the time to explain procedures relating to labour, birth and parenthood and as a result, they felt more supported and prepared.

"They also get down to a person level with you, they can relate and just talk to you like you're human" [Alison, FG 2]

"I think they're great I do, they're helpful in every way. They're helpful in everything they do" [Molly, FG 4]

"I had a nursery nurse come out to bath and stuff, safe sleeping and labour" [Emily, FG 4]

"It's nice that they're around for longer as well, midwives they just discharge you and that's it and then you have to like, do it on your own" [Alexa, FG 3]

As Amanda and Bonnie indicate below, they really valued this support:

"They're just really supportive, like when you're pregnant you're so emotional, I think I cried, I probably cried to [staff] so many times, but she was just there" [Amanda, FG 3]

"They're so helpful as well. You know if you tell them something, they always have something to try and help you" [Bonnie, FG 3]

**Knowledge and Information – Before and After Birth**

The services that JIG-SO provide aim to not only support young parents, but also provide them with knowledge and information so they can make informed decisions on the way they wish to parent their children. Overall young parents reported that the service educated them about everything they need to know for pregnancy, childbirth and parenthood.

"She'll be brought up differently to how she would have been brought up if I didn't have JIG-SO because the things they've taught me" [Hannah, FG 4].

**Antenatal**

An observation of the antenatal group session showed that practitioners went through every aspect of childbirth through a role play scenario, with the integration of props giving the parents a sense of a real-life situation. The young mothers felt comfortable to ask questions and advice about queries they had. It was reported that they got more than their standard midwifery sessions and felt the information focused on what they needed to know at that specific time, and they were not overloaded with pregnancy information. They were provided with valuable detailed information relating to safe sleeping, baby massage and feeding methods (both breastfeeding and bottle feeding) and safe sterilisation which the young mothers felt made them more confident to look after their babies.

"I would not have been able to go through labour if [staff member] had not talked me through it" [Emily, FG 4]

"Just to widen our knowledge about the way in which the baby develops, things that we can do to keep the baby healthy whilst I was carrying him" [Anabelle, FG 2]

"I've had baby massage come out to my house, I had one on one help with that" [Elise, FG 2]

"When [name] was first born I had like a nursery nurse coming out to do bathing with me first, then feeding, then everything like that. Yes it is really good, really helpful…not every baby comes with a manual" [Molly, FG 4].

**Post-natal**

After childbirth JIG-SO offer services, which provide the young parents with information relating to parenting styles, confidence building, the growth and development of the child and relationships. The service users we spoke to reported finding this information beneficial and allowed them to develop their parenting skills without being judged over decisions they made and in turn, they felt they were being the best possible parent.

"It's the knowledge that stays with you and it doesn't go anywhere" [Anabelle, FG 2]

"They educate you…because when you do become a new parent….there's no book for it…They touch upon this stuff in groups, but they don't overload you with information…simplify it down and let you understand" [Ben, FG 1]

They also reported being provided knowledge they were unaware of, including how growth and development is affected by connections with work focused around *The 1001 Critical Days* (Loughton 2015).

"It was just a bit of everything really, they do parenting, they do skills, they do building, they do like connections with each other, pretty much everything you want to know about" [Sandra, FG 4].

"In here we learn about different connections a child makes in their head and about how they learn and how they think and they have different emotions to us…you need to understand that so you can sort it out without getting frustrated" [Elise, FG 2].

"We have literally just widened our knowledge on everything really and just how to be good parents to a child" [Anabelle, FG 2],

**Social services**

Building on the quantitative findings presented above, the young parents we interviewed reported how JIG-SO had been helpful and supportive during the period they were open to social services.

This support included practitioners attending meetings and informing them on procedures and information in place, as prior to this they felt uninformed. Of the young parents who spoke about social services they all said that it was because of the support, guidance and knowledge they received from JIG-SO that they still had their children.

"It really helped me, I don't think I'd have my baby if it weren't for them" [Emily, FG 4].

"I didn't think I'd be here with my two kids, but they made me know where I stand, they made me know what was coming next, I knew what was going to happen" [Molly, FG 4].

"They attended every single meeting as much as they could. They attended my school meetings, they attended child in need meetings…every 4 weeks I had a conference, they attended everything for me and it really helped me" [Emily, FG 4]

"They helped get social services off my back, they helped me loads with that … and came to meetings and stuff" [Bonnie, FG 3].

In the next section of the report we move on to explore another service run by the JIG-SO family facilitators, the six-week healthy relationships education programme that young parents and expectant parents could attend. It was here that young men and women could come together to discuss different aspects of their relationships or relationships with family members or friends if they were not in a 'intimate' relationship at that time.

**Part Three: Relationships Programme and Young Fathers**

The Relationships Programme was aimed at exploring different aspects of a 'dating' or intimate relationship through a non-formal six-week educational course. A member of the research team joined at the start of a programme with a new intake of service users and engaged with them over the length of the course[2]. Service users attended voluntarily and could join the programme at any time [see appendix 2]. They were referred from members of the JIG-SO team if there was some concern surrounding the young parent's relationship, the behaviour of them or their partners and the impact of this on their child or expectant child. Some of the attendees had previously had children removed by social services, and others were on a current 'at risk' social services register. The classes were run by two family facilitators [Mark, and Georgia] but also helped by other members from the JIG-SO team when circumstances meant they could not facilitate the group. [see Part Four of our findings for a discussion about this collaborative working]. Young mothers, fathers and other members of the service users' families or friends, also came together to discuss what a healthy relationship looked like and how this could impact on their child. Two main themes appeared from the relationships programme: the creation of a safe friendly space by staff to discuss challenging/uncomfortable issues, and the challenging of gender norms and promoting 'caring' masculinities amongst the young fathers.

**The creation of a safe space by staff**

Each weekly session took place in a community hall, near the centre of Swansea, for two hours and ran on consecutive Thursdays. This meant easy access for service users who attended by public transport. The hall was bright, warm and clean with a small kitchen where hot drinks could be made. Each session occurred around a large table in the centre of the hall. Here staff members and the attendees would sit, and work through a programme of interactive activities using games, quizzes, worksheets, flipcharts, film clips, and pair/group exercises that were dedicated to discussing various issues surrounding being in a relationship.

Some of these exercises included evaluating a relationship and what people looked for in a relationship [week 1]; ideal partners and balancing relationship time, the A,B,Cs of dating [week

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[2] Due to the flexibility of the programme and the JIG-SO team, the full programme lasted eight weeks to cover the material and to discuss complex issues that arose.

2]; parenting styles and childhood experiences [week 3] ; dealing with conflict, anger and stress in a relationship [week 4]; anger escalators [week 5]; communicating with a partner and children [week 6/7], and discussing feelings and moving forward [week 7].

In order to do this work, an open, honest and guiding approach was adopted by the family facilitators to create a safe, inclusive space, both physically and emotionally:

> Around half a dozen tables had been pushed together and set up in the middle of the room, with chairs around them and a range of biscuits, cakes, and fruit laid out on the surface. As each attendee entered the room, they were met with a friendly greeting and asked if they wanted a hot drink. [Fieldnotes]

At the beginning of the programme the facilitators asked the attendees for their own ground rules and to define what was acceptable behaviour in the group, this gave the young people a degree of control in the process. These rules were returned to at the start of each week and it was stressed that what was said in the room should stay in the room and to not use social media. The family facilitators already knew many of the attendees, so a certain level of rapport existed and they could engage the young people in the exercises and discussions about often difficult topics [anger, violence, partner control] through different strategies. One of these included using the names of the service users' own children, or their own experiences as staff to give some context. The ability to manage the environment and to know what the young people were feeling in this space, was also crucial:

> At the end of the session today, Mark told me that Adrian had control issues and he could tell that during part of the afternoon, Adrian had gone very quiet, slouched down in his chair and had been staring hard at other people in the group that were interacting with Cassie [his partner]. Mark had noticed this and gone out to him at the break and at the end to have a quick word with him about this. [Fieldnotes].

> I chatted with the group as we moved around getting fresh cups of tea and coffee and eating the food provided. We also talked a little about arguing in a relationship and how to have a 'safe argument'. Mark by this point had moved from his position at the front of the room, and was now sitting as part of the group, alongside me and Gwyn.

Mark leaned back in his chair as he talked, he appeared very casual and non-judgemental. [Fieldnotes]

This non-judgemental approach had the double benefits in terms of getting some of the young mothers to think about their parenting skills, which came out organically in the following conversation where Mark got Cassie to question her need to bring her own baby to the sessions:

Mark [who told me he had been running this class for about four years] has a very open, friendly manner, using a lot of humour, much of it self-deprecating, which seemed to cause a lot of laughter in the group. His approach was very non-judgemental, but I also noticed how he would often get the attendees to think twice about something that was being said, never telling them that 'they should do this' or 'they should do that' but getting them to ask questions of themselves. For example, at one stage during the ideal man vs woman exercise, Cassie asked if she could bring her baby to the next session. Mark was very quick to say that it was an inclusive space and that all babies were welcome. But he also asked Cassie some questions about how long she was away from her baby per week, and who was looking after the baby this afternoon. Was the baby safe? Was the baby learning anything about being apart from her? And was she learning anything about being away from her baby? Throughout these really open, carefully worded questions, Cassie then talked about her own separation anxieties and looked to have a lightbulb moment and her face changed and eyes lit up. She seemed to piece together what Mark was saying. Of course she could bring her baby into the space, but she and the baby were learning important things whilst being apart e.g for her overcoming separation anxiety, for the baby learning to be away from it's mother and that it's mother will return. Mark then linked this back into the lists that were pinned on the board, and said that the baby would learn that it's mother was being reliable and would return in time. [Fieldnotes]

This non-judgemental and friendly approach was appreciated by the young people who attended and they told me why they liked coming:

'Good to get out, I like coming, I have friends' [Matt]

'Good to talk about this stuff, gets you thinking you know' [Adrian]

'I enjoy being around other people and it's not like school at all' [Sarah]

Sarah's comment, that 'it's not like school' is telling, as the non-formal programme was delivered in a very interactive, service user led approach at times, which would have been different to many of these young people's formal educational experiences.

**Challenging gender norms and creating 'caring' masculinities**

Each session was dedicated to discussing various issues surrounding what constituted a relationship and how this impacted on being a parent. This was done is a very realistic way by the facilitators, who noted on numerous occasions that this didn't mean that both parents must be together or that as young parents they would likely stay together for the rest of their lives. These conversations and exercises were often springboards into other more serious topics, many of which centred on gender roles and enabling the young fathers present to think about their own identities as young men and what it meant to be a man.

Mark outlined why some of the men were here, and why learning to be a good father involved 'growing up fast', and to try and lose those 'macho' behaviours. [Fieldnotes]

In discussions in the early sessions, the young men were asked to define 'macho' behaviour and what being a man meant to them [and their partners] and the impact this had on being a father. The facilitators helped start these discussions:

Gwyn drew on his own experiences of being a mechanic for 20 years and learning how to be a man in that environment. Mark also talked about his background and how he had a very abusive violent father [an ex-soldier] growing up and that he himself had gone into the army, which was a very tough place. Both facilitators stressed that these behaviours were damaging to men. Also, there were some discussions here about the breadwinner role expected of men. Mark also commented on his and Gwyn's physicality [both are tall white men] with bald heads, these traits he suggested are often associated with aggressive guys. [Fieldnotes]

It was through these discussions that the young fathers talked about their own experiences and Mark could highlight how some practices were more likely to be engaged in by men more than women e.g. playing video games, and sports, and that men were more likely to

engage in risky behaviours such as drinking excessively, driving cars very fast and being violent and aggressive.

> The conversation then turned to cars. Laura stated [in relation to her partner Jacob] 'he cares more about his car than me!'. Mark used his past interests here again to connect with these boys, [bikes, cars etc] and he pointed out that a fast, noisy car is not perhaps the ideal vehicle for a baby. He then mentioned how the boys in the group might need to be more practical. [Fieldnotes].

Again here Mark drew on his previous experience to connect with the service users, but also to offer alternatives. By discussing how the excesses of men's behaviour can have negative consequences, Mark was able to suggest an alternative more 'caring' masculinity (Elliot, 2016) that was needed when becoming a father. Advice was given that when a baby comes along, to be a good dad, young men's values might need to change e.g. give up the lad lifestyles, or to at least restrict these excesses to certain occasions. The family facilitators also encouraged the young men to discuss one's feelings and to learn how to manage one's stress and anger by learning from the tools taught on the project.

Some of the young men talked very positively about what they learned from these exchanges. In a conversation with one young man I asked him what he got out of the group and I was told '(it) teaches me not to beat up my missus' [Adrian]. Other young men were also modelling examples of caring masculinity in the sessions by engaging and being responsible for their babies by holding and soothing them, changing nappies, feeding them and playing with them. This does not necessarily suggest that these young men are committing some sort of heroic act for doing the work that is 'expected' of young mothers. Instead what this seems to highlight is how engaging young fathers in the process is possible (see Tarrant and Neale 2018) and how discussions around acceptable practices for men, have benefits for them, their children and importantly, their partners.

However, this was not to say that these discussions had an immediate impact and some of the young men caused concern for the family facilitators. After one session, Georgia was at pains to tell me that she had been working one-to-one with one of the young mothers who attended the group with her boyfriend. They had recently had their baby removed by social services and Georgia was concerned about bruises that appeared on the young mother's face and how reliant and passive she appeared to be in front of her boyfriend.

In conclusion, this programme provided advice on what a healthy relationship between parents might look like and through the groups' facilitators, it provided a safe space to discuss often challenging topics. These included what abusive partner behaviour looked like, strategies for challenging stressful situations, coping with arguments and dealing with disagreements. It was in this safe space that young fathers were encouraged to talk about their ideas of what defines masculinity and being a man. Through exercises which challenged gender stereotypes and discussions around what traditional masculine practices looked like, young men were able to questions the consequences of destructive or negative behaviours on themselves, their partners and children. It was here that a 'caring masculinity' was fostered.

**Part Four: JIG-SO team members**

This section reports the findings from non-participant observations and two focus group interviews with the multi-agency JIG-SO team (see Appendix 3). The whole team has its base in a high-rise building in the centre of Swansea. As we have outlined in this report, this mode of collaborative working is innovative and throughout Wales (and the UK) it is unusual to have Midwives and Local Government-employed workers co-located in this manner. The findings from this part of the study illustrate the likely impact that this co-location has on the service and its outcomes and staff members' thoughts about this collaborative way of working.

**Office environment**

During the three non-participant observations of the team (n-17) working together in the JIG-SO office it was clear that the team members were very relaxed with each other. The administrator and the managers sat in the same space as the rest of the team. When the researcher attended, a radio was always playing music in the background, and the team members talked briefly about their own personal lives using humour that appeared to contribute to building and supporting their personal and working relationships. They commonly referred to the service users, asking each other for advice and ideas:

Georgia (talking about a new client who she said appears rather 'flaky' lately):

'I did not sleep last night.'

Gwyn (overhearing what Georgia has been talking about):

'You worry too much, you do.'

However, Gwyn quickly moved on to ask more about the situation and a long and detailed discussion in the open office followed about how best to match members of the team to the young person – they debated the benefits of offering the service user a more 'motherly' or more of a 'friend-type' supporter. Everyone else present joined in and a decision was made about who would join Georgia for the next visit later that day.

[*Observation Extract 1*]

This sort of open (but discreet) discussion was observed in all three observation periods. Some of these discussions were about clients with very distressing histories including human trafficking, sexual abuse and childhood drug use.

> Midwives and Local Authority staff sat around a single desk area and communicated in an open, accepting and mutually supportive manner, often sharing food, snacks and treats while making arrangements for group activities and 1:1 meetings with clients and families. People come and go and Gwyn occasionally sits at a desk nearby, getting up at times to make tea and coffee for the staff and he provides encouragement, offering advice and input into their plans.
>
> [*Observation Extract 2*]

The team members appeared to know the clients very well; one example (of very many) relates to a client who had been doing well, getting out and about with her baby and breastfeeding well but who had recently suffered a rare health problem, which resulted in her not being allowed to drive and her needing to stop breastfeeding.  All those present were visibly upset about her situation:

> Rachel: 'I'm gutted for her…..I'll drop her a text and see if she wants a chat.'
>
> [*Observation Extract 3*]

> On one occasion Gwyn took a call from a young person who reported that she was 'having a breakdown'. The team went into a semi-emergency response mode and they decided who would be best to go and help her. Within 10 minutes two Family Facilitators left to visit the client.
>
> [*Observation Extract 4*]

There were also a number of occasions when the location in the office was potentially very beneficial to the project and the clients; these include interactions across the office with *Flying Start* and managers of  other local authority services including the '*Team Around the Family'*, the '*Parenting Team'*, *'Family Wellbeing'*, the '*Early Language Development Team'*.

**Focus Group Interviews**

Two focus groups were planned to include mixed members of the team. However, due to work pressures, while the first included Midwife Team Members and Local Authority Team Members [Family Facilitators, Early Language Development Workers, Nursery Nurses] the second focus group had no midwives involved. Two key themes emerged from the focus group data alongside the observations; these were 'Flexibility' and 'Commitment'.

**Flexibility**

The way in which the team members discussed cases, gave and accepted support and advice and made plans for their work was evident during the observations and in the focus groups. For Paula team culture was very important and she talked passionately about how the team tried to support the young families they worked with in any way they could:

'Yes, that's not us as individuals because I think as individuals, we will do anything and everything that we can in any way to support our families that we work with. You know, above and beyond really. I know we've got a worker where a Mum was in labour over the weekend and she had nobody around her, no family, totally excluded from everything. She came from England down here, and I know this particular worker was visiting, just popping in on the weekend just to check in that everything was ok you know…because this person had nobody.' [*Paula FG 2*]

Mark talked further about this team culture and how he felt that there was a real collective approach to support:

'We are very happy to say to our colleagues 'can you help me out with this one?'. We are all busy but I think we'll all say 'I'll try and do this for you, I'll try and do that.' It's not your group, it's not my group, it's ours.' [*Mark, FG 2*]

As Jade explained further, part of this collective approach was enhanced by a degree of trust and flexibility in their roles:

'It's never been 'this is your role, this is your role', and we've all been given freedom to kind of do what we feel is the right thing to do with that family. So we've never, I have never felt that I have to go in and I have to do certain things and under pressure to kind of achieve x y and z/'[*Jade FG 2*

Team members talked about how they always did what was needed in the moment, doing things that were usually well outside of their previous job role(s). However, this was usually done as a common approach, which Cath outlined in FG 1.

'I think that's the common ethos of the team, that we all care because you know, it doesn't say anywhere in my job description that I go and get people food parcels, but that's part of my care and compassion for that person. If I go in there and she's 7 months pregnant and got no food, I see it as my duty of care to help her, so I will physically get a food parcel and take it and make sure that they're looked after. And those are the things that make a difference, those little things, for that person and its massive isn't it, that somebody cares enough to think well you haven't got any food'. *[Cath, FG 1]*

This practical approach to situations e.g providing emergency food parcels, was expressed further by other members of the team:

' if you've got no food in the cupboard (Tracy) it invariably affects the baby doesn't it you are not going to want to talk about GroBrain or breastfeeding or write your birth plan because your mind is much more preoccupied on the fact that your starving and you've got no food ' [*Tracy and Mark, FG2*]

Regardless of policy initiatives which promote early intervention parental strategies based on pseudoscientific biological initiatives such as *The 1001 Critical Days* and *GrowBrain* initiative (Loughton, 2015) the difficult socio-economic circumstances and levels of poverty, did not escape team members.

'You might go there to do for instance breastfeeding which is planned for an hour, and you get there and she's in floods of tears because she's losing her home, she's got no food in the cupboard. So then that session becomes much more of you know, the social aspect really and you know, getting hold of tenancy support workers or social services or, you know so your planned visit might not materialise, it's just how it is because of the nature of the clients referred to us you know.' [*Penny, FG 1*]

Throughout the interviews, there were a number of references to how their work allowed them the time to get to know families. They were not expected to get results in a very short time period and

they valued the teamwork and the freedom to work together and decide between themselves on the best approach for that client at that time:

'I just think we're very lucky that we've got flexibility to do our jobs basically and it's not 4 weeks, 5 weeks whatever because that relationship building is probably one of the most important things for this role.' [*Carys, FG 1*]

'In the office when I see people talking together about issues that they may have or some things that they need to talk about with other members of the team, everyone is always really happy and willing to jump on and help and support and I think everybody, doesn't matter whether its council or health whatever, manager, everybody helps out and gives support to everybody. That's the best part, very good support from the team.' [*Jade, FG 2*]

**Commitment**

Throughout this part of the study the commitment of the multi-agency team members was ubiquitous. It was evident in the observations of the office that they demonstrated their commitment to each other and to working together to ensure the best possible outcomes for the young people they worked with:

> Another client – fostered girl – boyfriend living with Nanna (discussed need for father's support). There had been a history of criminal activity and serious Adverse Childhood Events. Midwife and Family Facilitator met the client before in Child-in-Need [CiN] meeting. In the CiN meeting more revelations about the family history came out (they have had 2 younger children removed). Midwives and others in lots of discussion about the case. Gwyn listened and reassured. Also discussed the father of the baby and his immaturity. Needs a Dad's worker. Discussed ACEs and who needs what. [*Observation Extract 5*]

The discussion was wholly non-judgemental, responsive and very open, with all participants listening to each other's suggestions in order to plan interventions and support in this very difficult case. Despite these very difficult conversations taking place, some members of the team were able to continue working on their computers and other devices while also stopping periodically to contribute to the discussion:

Tracy came in – phoned a client to arrange a group. People from other areas using the photocopier & making / taking calls. Interaction between Gwyn and other managers – clarifying the content of a policy document. No one seems to mind being disturbed from what they are currently doing. Very responsive and open attitudes from everyone. [*Observation Extract 6*]

Team Members were also very accepting of each other's capabilities and respectful of their input. However, they were also keenly aware that this was because of who they are and how they came to be together. How the group grew was evident in the Focus Group, and this involved a lot of hard work as Mark explained:

'I also think the project has grown, it's grown it hasn't happened overnight. So, initially it was just one midwife, then the midwifery team got together with the nursery nurse, then Tracy and I came across and then we did that for like a year and a half. When I did it, it was part of the *Teen Start* and it was from that success the team grew. So, it's had stages of development, so where there may have been, I think potentially me and Tracy have always had a good working relationship and its worked very well with the midwives, the smaller team back then. And that, it was a good foundation, there's a lot of work that went in, there's a lot of that building a relationship between our role and midwifery and a lot of understanding. We used to do a lot of joint visits back then, everything was in tandem with midwifery. It wasn't something that was done half-heartedly there was a lot of energy went into that. We had a lot of meetings, in those early days, what are our roles, how would this be, what would be the benefits.' [*Mark, FG 2*]

The focus group respondents valued each other as people very highly and they pointed out that the leadership within the JIG-SO project was a key aspect of their commitment:

Tracy (talking about Gwyn) 'I think he is very passionate, we have been fortunate in terms of managers - that the people who have managed us right from the beginning have been so passionate about what we do. And it definitely, kind of motivates you and kind of trickles down through anybody who comes into the team. Gwyn especially I think, and what has always been nice about Gwyn is he never expects you to do anything he doesn't do himself. He's part of, even though he, whether he should be or shouldn't be or there's time to do it, he is always, everybody knows, all our families know him, he knows all our families. And he gets involved in everything….' *[Tracy, FG 2]*

Jade added to this by emphasising that there was not a gendered dynamic to this help either, and Gwyn would help out in more traditionally female dominated spaces – 'Even if we're short staffed in child care, you'll find him in childcare you know.' [*Jade, FG 2*]

In conclusion, it was evident from the observations in the JIG-SO office and the focus groups that the team comprises a particularly committed group of people drawn from across several disciplines who have, over time, merged together into a responsive and flexible team. Their working environment, their inventive 'can-do' attitude and their ability to work under pressure to provide non-judgemental care and support to very vulnerable young people, while maintaining and developing their own professional skills is impressive.

**Section 4/ Conclusion and implications**

This report set out to address three research objectives

- To explore in what ways the JIG-SO project is 'working', from the perspectives of service users and service providers.

- To discover how the project might be improved.

- To consider how the project might be replicated in other areas of Wales (and the UK).

As the previous section outlined, our research has found that within JIG-SO there are close, collaborative working relationships and joined up practices between the multi-agency partners, enabling a high level of communication to meet service users' often complex needs. These practices within JIG-SO created a team or 'family' unit around a young parent and link into the Welsh Governments '5 ways of working' initiative (Welsh Government, 2015). The key messages which emerged from this research can be summarised as follows:

**'Support' was multi-layered:**

Different programmes of support were available pre and post birth to provide an invaluable level of health and social care for young parents and their children. This support was fostered by the multi-agency workers through 1:1 work, but also through the facilitation of family support group classes and forums.

The range of support, including a six week relationships programme, aimed at both expectant and new parents allowed them to share their experiences and learn from others accessing JIG-SO services and to build friendships and parental networks with each other.

The young parents reported positive relationships formed with members of staff due to the personal attributes of the practitioners. They defined these as being supportive, friendly, empathetic, reliable and non-judgmental, which allowed them to feel like they were cared for and could connect on a personal level. They also stated that they benefited from additional hours with practitioners because they took the time to explain procedures relating to labour, birth and parenthood and that they also took them to food banks, provided advice on employment, education, housing or universal credit issues and as a result, they felt more supported and prepared to be a parent.

**A collaborative approach led to better outcomes for the young parents in several ways:**

A large proportion of young people who were referred to the project by the local authority, were closed or removed from the social services' 'at risk' register. After engaging with the team children were more likely to remain in their families. There were also improvements in health outcomes including smoking cessation, alcohol use, healthy eating and breastfeeding.

**Implications**

- At a time when funding and the futures of support services are under threat, this report demonstrates the vital role that agencies such as JIG-SO play in supporting young families to live healthier lives, both physically and socially. By learning from this example of good practice, and drawing on the expertise from this collaborative approach, other local authorities could greatly benefit from what we term the 'JIG-SO model'.

- This study adds to the existing body of knowledge of how parenting programmes can provide support for wider social determinants of health including housing, employment and furthering education which can contribute to the health of individuals and should be seen as an example of good practice. Some improvements could be made in terms of closer links with educational institutions within the area, and bringing in adult educators to the JIG-SO team could provide tailored packages of support.

- Additionally, this research also adds to a small body of knowledge which explores how the inclusion of fathers in these programmes can benefit the whole family and help prepare them for the journey ahead. There was an awareness within the JIG-SO team of how traditional expectations of masculinity impacts on young men and their behaviours as young fathers and partners. This is another example of good practice and integral to the 'JIG-SO model' that other local authorities could benefit from.
- Finally, this report highlights how JIG-SO operates within a troubling policy backdrop which includes *The 1001 Critical Days Strategy* and *Adverse Childhood Experiences* [ACEs] agenda. We argue that these are individualized solutions that often ignore poverty and inequality and are only part of what is needed to combat the disadvantages socio-economic circumstances which shape young parents' lives.

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**Appendix 1 – Participants in the antenatal and peer support group sessions**

|  | Male | Female | Total |
|---|---|---|---|
| Focus Group 1 | 1 | 4 | 5 |
| Focus Group 2 | 1 | 3 | 4 |
| Focus Group 3 | 0 | 5 | 5 |
| Focus Group 4 | 0 | 4 | 4 |

**Appendix 2 -Participants in the relationships education programme**

| Week 1 | Week 2 | Week 3 | Week 4 | Week 5 | Week 6 | Week7 |
|---|---|---|---|---|---|---|
| MW (R) | MW [R] | MW [R] | MW [R] | MW [R] | MW [R] | MW [R] |
| Gwyn (S) | Mark [S] | Mark [S] | Mark [S] | Gwyn [S] | Gwyn [S] | Mark [S] |
| Mark (S) | Georgia [S] | Georgia [S] | Georgia [S] | | Georgia [S] | |
| Adrian and Cassie [SU] | Adrian and Cassie [SU] and baby | Adrian and Cassie [SU] and baby | | | | |
| Sarah and John [SU] | | Sarah and John [SU] | | | Sarah and John [SU] and baby | |
| Jacob and Laura [SU] | Jacob and Laura [SU] | | Jacob and Laura [SU] | | | |
| | Simon and Kim [SU] | | | | Simon and Kim [SU] | Simon and Kim [SU] |
| | Bella and Craig [SU] | | Bella and Craig [SU] | Bella and Craig [SU] | | Bella and Craig [SU] and Carly [F] |
| | Jim and Michelle [SU] | Jim and Michelle [SU] | | Jim and Michelle [SU] | | |
| | | Jennifer and Matt [SU] and baby | Jennifer and Matt [SU] and baby | Jennifer and Matt [SU] and baby | | Jennifer and Matt [SU] and baby |
| | | Kim [SU]and Tina [F] | Kim [SU]and Tina [F] | | | |
| | | | Gemma [SU] | | | |
| 9 | 14 | 15 | 13 | 9 | 8 | 10 |

**Key**
R – Researcher
S- Staff
SU -Service User
F- Family member of friend of Service User [SU]

**Appendix 3 JIG-SO staff – Observations and Focus Group Interview Participants**

| | |
|---|---|
| Manager | Gwyn |
| Family Facilitator | Georgia |
| Family Facilitator | Chloe |
| Family Facilitator | Tracy |
| Family Facilitator | Mark |
| Early Language Development Worker | Paula |
| Early Language Development Worker | Jade |
| Nursery Nurse | Alice |
| Nursery Nurse | Lowri |
| Nursery Nurse | Marie |
| Nursery Nurse | Sian |
| Midwife | Tina |
| Midwife | Cath |
| Midwife | Rachel |
| Midwife | Charlie |
| Midwife | Penny |
| Midwife | Carys |